

Physicians don't follow guidelines: What are we to do?

Simos and colleagues reported that Ontario surgeons and oncologists don't follow guidelines when ordering imaging in women with early-stage breast cancer.¹ The paper joins tens, if not hundreds, of similar articles describing the failure of practising physicians to follow guidelines.

Over the last two decades, repeated attempts have been made to “transfer” or “translate” knowledge to practising physicians.^{2,3} The CMA maintains a database of “approximately 1200” clinical practice guidelines.⁴ The plethora of published guidelines have had little appreciable effect on physician behaviour. Even the use of moral suasion by labelling guidelines “best practices” has not worked. What is the matter with practising physicians?

We don't understand what physicians-in-practice consider as evidence or how they incorporate and use it in their practices. There is some ethnographic research that indicates that the process is complex and nonlinear.⁵ Clinicians are aware of guidelines but do not refer to them directly in their day-to-day practices.⁶ Evidence used for practice comes from multiple sources, and not all of it comes from approved hierarchies of validity.⁶

We know physicians do not use guidelines in their practices. Producing more evidence of this fact doesn't help us understand why they do not. It is clear that new knowledge does not get transmitted through the rational, linear, transfer models we assumed would work. Until we put research efforts into understanding how clinicians actually practise, we will continue to be stuck — wringing our hands and reading more reports that state that physicians don't follow guidelines.

Don Eby MD PhD

Grey Bruce Health Services, Owen Sound, Ont.

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Aspergillosis spores and medical marijuana

Thank you for your perspective on medical marijuana as a safer option to narcotics for immunocompromised patients.¹ As respirologists, we would like to bring to the attention of all health care workers and administrators the other effects of inhaled marijuana on the respiratory system, whether irradiated for *Aspergillus* spores or not.

We are seeing a growing number of patients being assessed by bronchoscopy who are marijuana smokers, including one young adult with a cavitating lesion in the right upper lobe associated with hemoptysis for which no other cause was found. As well, some of our most difficult-to-treat patients with asthma have used inhaled forms of marijuana before.

Apart from the adverse medical consequences of inhaling marijuana, health care costs are likely going to rise owing to Health Canada's approval of medical marijuana in an inhalant form. A review of the current and proposed policies on medical marijuana is needed to avoid unnecessary extraneous costs to the health care system over the next decade. If legalization does occur, a strong case should be made for legalizing only noninhaled forms.

Dilini Vethanayagam MD

Emad Saad MD

Jaled Yehya MD

University of Alberta, Edmonton, Alta.

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Psychedelic and nonpsychedelic LSD and psilocybin for cluster headache

Tupper and colleagues highlight reasons for renewed interest in the use of psychedelic drugs as adjuncts to psychotherapy.¹ Clinicians have an interest in extending research into headache medicine, especially the treatment of cluster headaches (prevalence roughly 0.1%) when episodes are refractory to standard therapies, including other serotonergic agents.

Patients with cluster headache have turned to LSD and psilocybin to abort periods of cluster headache.² This may often occur without the involvement of patients' health care providers.³ Of interest, an open-label study found that similar compounds (2-bromo-LSD) without psychedelic effect were promising for this purpose.⁴ I hope that Tupper and colleagues' contribution to an open discussion of these treatments will encourage more research and better treatment for patients with a variety of disorders presumably linked to serotonin.

Wm. Jephth Davenport MD

Cumming School of Medicine, University of Calgary, Edmonton, Alta.

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